



Federal Employees
Health Benefits Program

- Complete Parts A and G, and Parts B C, D, E, and F as applicable.

Health Benefits Election Form

Federal Employees Health Benefits Program

For Employees, Former Spouses Under the Spouse Equity Law, and Individuals Eligible for Temporary Continuation of Coverage

Do not separate the copies. Your employing office will certify the completed form and return your copy to you.

Form Approved:
OMB No. 3206-0160

- Type or print firmly
- Sign and date in Part G

PARTA - Fill in this part.

1. Name (last, first, middle initial)	2. Social Security number	3. Date of birth (mo., day, yr.)
4. Your home mailing address (include ZIP code)	5. Sex Male Female	6. Are you now married? Yes No
	7. Daytime telephone number (include area code) ()	

PARTB - Fill in this part if you wish to enroll or change your enrollment in the Federal Employees Health Benefits (FEHB) Program.

1. I elect to enroll in a health benefits plan as shown below. (Copy the information requested below from front cover of brochure of the plan you select.)					
Name of plan					Enrollment code
2a. Names of family members (last, first, middle initial)	2b. ZIP code	2c. Date of birth (mo., day, yr.)	2d. Sex	2e. Relationship "code"	2f. Social Security number (see instructions)
3a. Do you, your spouse or any other eligible family members have any group health insurance coverage other than the FEHB plan in which you are now enrolling or enrolled? No Yes					Name of policy holder (last, first, middle initial)
					Complete 3b
3b. Type of insurance	Medicare You A B	Your Spouse A B	TRICARE (Including CHAMPUS)		Other (specify name)

PARTC - Fill in this part, as well as PART B, to change enrollment.

1. Present Plan name	2. Present Plan enrollment code	1. Event code that permits change (see Table of Permissible Changes)	2. Date of event that permits change (mo., day, yr.)
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PARTE - Employees Only

Place an "X" in the box below if you wish NOT TO ENROLL in the FEHB Program.

☐ I elect not to enroll in the Federal Employees Health Benefits Program.

My signature in Part G certifies that I have read and understand the information on page 4 regarding this election.

PARTF - Cancellation

Place an "X" in the box below if you wish to CANCEL your enrollment.

☐ I elect to cancel my enrollment in the Federal Employees Health Benefits Program. I am currently enrolled under the code shown at the right.

My signature in Part G certifies that I have read the information in the instructions on page 4 regarding cancellation of enrollment and that I understand that I must meet the 5-year requirement to qualify for FEHB coverage after retirement.

PARTG - Fill in this part.

WARNING: Any intentionally false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than \$10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001.)

1. Your signature (do not print)	2. Date (mo., day, yr.)
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PARTH - To be completed by agency

1. Name and address of employing office (include ZIP code)	2. Date received in employing office (mo., day, yr.)	3. Effective date of action (mo., day, yr.)	4. SF 2811 report number
	5. Payroll office number	6. Payroll contact and telephone number (including area code) ()	
	7. Personnel contact and telephone number (including area code) ()		
	8. Signature of authorized agency official and telephone number (including area code) ()		

Remarks